STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155674	A. BUILDING 00 B. WING	05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CHARLES HEALTH CAMPUS	3150 ST CHARLES ST JASPER, IN47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This Survey was for a Recertification and State Licensure Survey. Survey Dates: May 23, 24, 25, 26 & 27, 2011 Facility number: 002628 Provider number: 155674 AIM number: 200299110 Survey team: Liz Harper, RN, TC Carole McDaniel, RN Martha Saull, RN Terri Walters, RN Census bed type: SNF: 15 SNF/NF: 33 Residential: 26 Total: 74 Census payor type: Medicare: 11 Medicaid: 19 Other: 44 Total: 74 Sample: 12 Supplemental Sample: 7 Residential Sample: 5	F0000	Plan of Correction Text: The submission of this plan of correction does not indicate an admission by St Charles Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of St Charles Health Campus. This facility recognizes it's obligation to provide legally and medically necesary care and services to its residents in an economic and efficient manner.The facility herby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (for Title 18/19 programs)To this end, this plan of correction shall seve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/6/11 by Jennie Bartelt, RN.			

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on interview and record review, the facility failed to ensure MDS (Minimum Data Set) assessments were accurate for 1 of 12 residents reviewed for MDS assessments in a sample of 12. Resident #1 Findings include:	F0272	F 272Resident #1 received an order for Occupational Therapy and has been evaluated and treated as deemed necessary per the therapist.Completion Date: 05/26/2011All residents have the potential to be affected by the alleged deficient practice therefore through systemic changes stated below the campus will ensure it completes MDS assessments	06/26/2011

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	On 5/24/11 at 1:00 P.M., the clinical record of Resident #1 was reviewed. Diagnoses included, but was not limited to, the following: transient ischemic attacks, depression, personality disorder and osteoarthritis. The most recent MDS (Minimum Data Set Assessment) dated 5/3/11 indicated the following for the resident's range of motion: no impairment for upper extremity (shoulder, elbow, wrist and hand). On 5/26/11 at 1:00 P.M., the MDS coordinator was interviewed. She was made aware of the observation of the resident on 5/24/11 at 8:30 A.M. regarding the positioning of the resident's right) fingers (being drawn toward the lateral side of the hand) and the resident being unable to successfully maneuver eating utensils. On 5/27/11 at 6:50 A.M., a copy of the "rehabilitation screen" was received from the DON (Director of Nursing). This change in status form was dated 5/26/11. Findings include: "Screen for possible AE (Assessment and Evaluation) needs at meals, 5/26/11 lunch - wouldn't attempt to hold utensil, only roll. Dinner-held utensil without any difficulty when she has it in her hand - grabs for food with her hands...may benefit from plate guard..."		accurately.Completion Date: 06/26/2011An in-service was completed concerning ROM assessments for the nurses and the MDS Coordinator. Systemic change is the MDS coordinator will complete a range of motion assessment quarterly and for significant change.Completion Date: 06/26/2011DHS/Designee will perform audits of 3 random residents to assure ROM Assessment are completed quarterly and with significant changes and coded correctly in the MDS 5x weekly x 1 week, then 3x weeky x1 month, then weekly with results forwarded to the QA Committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completion Date: 06/26/2011	

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	On 5/27/11 at 10:30 A.M., the MDS coordinator was interviewed. She indicated she didn't know when the change in the resident's right hand occurred but she will complete a change in condition MDS regarding the resident's limitations in her right fingers. At this time, the ADON (Assistant Director of Nursing) indicated they had received a physician order, dated 5/26/11 for OT (Occupational Therapy) eval (Evaluation) as indicated for A and E (Assessment and Evaluation) and possible right hand positioning devices." At this time, the MDS coordinator indicated on the resident's right hand, her index finger and thumb were without limitation. She also indicated the remaining 3 fingers on the resident's right hand were resting in a manner which appeared pulled to the right (or lateral side) and the MDS coordinator demonstrated the resident was not able to separate her fingers to the full extent. On 5/27/11 at 10:50 A.M., the DON (Director of Nursing) was interviewed. She indicated the facility wanted the resident to be as independent as possibly with her eating. On 5/27/11 at 11 A.M., the MDS coordinator provided a current copy of her reference for the MDS condition change. This documentation was from the "CMS's			

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	(Centers for Medicare and Medicaid) RAI (Resident Assessment Instrument) Version 3.0 manual" and was dated September 2010. This documentation indicated the following: "The SCSA (Significant Change in Status Assessment) is a compressive assessment for a resident that must be completed when the IDT (Interdisciplinary Team) has determined that a resident meets the significant change guidelines for either improvement or decline..." 3.1-31(a)			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview and record review, the facility failed to ensure the resident's plan of care was current in regard to her difficulty maneuvering eating utensils and/or food in the restorative dining room for 1 of 3 sampled residents reviewed for meal consumption in the restorative dining room in a sample of 12. Resident #1 Findings include: The clinical record of Resident #1 was reviewed on 5/24/11 at 1:00 P.M. Diagnoses included, but were not limited to, the following: dementia with psychotic features, osteoarthritis, transient	F0279	F 279Resident #1 care plans have been reviewed and updated as applicable.Completion Date: 06/06/2011All residents have the potential to be affected by the alleged deficient practice therefore through systemic changes stated below the campus will ensure the resident's care plan is current.Completion Date: 06/26/2011An in-service was provided concerning care plans for nursing staff. Systemic change is Interdisciplinary Team will update plans of care as changes occur.Completion Date: 06/26/2011DHS/Designee will perform audits of 3 random residents to assure care plans are current in regards to the resident's current condition 5x weekly x 1 month, then 3x weely	06/26/2011

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	ischemic attacks, and depression. The most recent MDS (minimum data set assessment) dated 5/3/11 indicated the following for the resident's range of motion: no impairment for upper extremity (shoulder, elbow, wrist and hand). A total summary score of 4 for cognition, indicated the resident was severely impaired. A speech therapy discharge summary, dated 1/12/11, indicated the following "Reason for Referral" "Pt. (patient) referred to therapy after recent decline in status. Pt is not doing better and desires to eat..." A plan of care, dated 2/9/11, addressed the following problem: "ADL (activities of daily living) self-care deficit...needs assistance or is dependent in...Eating...Interventions included, but were not limited to, the following: Assess/record self-care status changes; report significant changes in ADL status...provide restorative nursing, eating...provide only the amount of assistance/supervision that is needed with ADL'S..." A plan of care, dated 2/9/11, addressed the following problem: "Alteration in comfort (arthritis). Interventions included, but were not limited to, the following:		x 1 month, then weekly with results forwarded to the QA Committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completion Date: 06/26/2011	

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	"Assist resident with ADLS as needed, encourage resident to consume 75-100% of ordered diet...encourage resident to exercise..." A Restorative Care Progress Note, dated 3/25/11 was reviewed. This entry indicated the following: "Weekly Note: Staff cont (continue) to see res (resident) for AROM (active range of motion) BUE (bilateral upper extremities)...et (and) eating. She is provided with V.C. (verbal cues) et demo (demonstration) she will return. 10 reps (repetitions) of flexion/extension exercises. She has limited range. She is also eating all meals in rest (restorative) dining room. She is served mechanical soft diet with thin liquids. Her meal is set up et (and) v.c. given. She will attempt self feeding however it varies. Staff assist as needed et she tolerates diet..." A plan of care, dated 4/11/11, addressed the following problem: "Restorative Dining." The documented goal was "Resident will feed self at least 75% of meal x 90 days." Interventions included, but were not limited to, the following: "Provide tray set up, gives cues and encourage to eat, assist as needed with meal consumption." On 5/24/11 at 8:30 A.M., Resident#1 was			

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	observed in the Restorative Dining room. She was sitting at the table with the following food in front of her: fried egg (uncut), a dish of dry cereal, a Danish roll (uncut), one slice of toast and a standard, regular, uncovered glass of orange juice. The resident was observed with a fork in her right hand, with the handle of the fork between the resident's right thumb and right index finger. The remaining three fingers of the resident's right hand were observed to be straight but in a slanted position, pulled to the right, starting at the base of the knuckle. The resident was heard to say, as she was stabbing at her fried egg with her fork, "I can't get ahold of it. I can't get it." The resident had stabbed the edge of the egg, with it dangling from one fork tine. LPN #1 came over to the table and stated, "I'll cut it in half." After the fried egg was cut in half, the resident was able to spear the egg and took it to her mouth. The resident was observed to be eating with standard utensils and a standard plate without any adaptive device. At 8:45 A.M., LPN #1 stated to Resident #1, "Are you going to eat Raisin Bran?" LPN #1 took a small glass of milk and poured it over the dry cereal. Resident #1 then reached for the standard spoon and grabbing the end of it again with her right thumb and index finger, tried to takes			

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	bites of the cereal flakes. Resident #1 moved the spoon from the cereal bowl to her mouth with no cereal in the bowl of the spoon for 3 of 5 attempts at eating the cereal. On 5/24/11 at 12:05 P.M., the Resident was observed in the dining room. She was struggling to pick up her fork with her right hand. The fingers of her right hand are positioned in a fanning manner to the right of her palm. CNA #7 stated "I'm going to help you" and came over to the resident and began feeding her. CNA #7 did not encourage the resident to eat independently but fed the resident. On 5/26/11 at 10:00 A.M., the DON (Director of Nursing) was interviewed. She indicated she did not find documentation where the therapy department had assessed the resident regarding her eating/self feeding skills. On 5/26/11 at 1:30 P.M., the DON was interviewed. She indicated they had called the physician office to get an order for therapy to evaluate the resident. On 5/27/11 at 6:50 A.M., a copy of the "rehabilitation screen" was received from the DON (Director of Nursing). This change in status form was dated 5/26/11. Findings included: "Screen for possible			

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	AE (assessment and evaluation) needs at meals, 5/26/11 lunch - wouldn't attempt to hold utensil, only roll. Dinner-held utensil without any difficulty when she has it in her hand - grabs for food with her hands...may benefit from plate guard..." On 5/27/11 at 10:30 A.M., the MDS coordinator was interviewed. She indicated she didn't know when the change in the resident's right hand occurred but she will complete a change in condition MDS regarding the resident's limitations in her right fingers. At this time, the ADON (Assistant Director of Nursing) indicated they had received a physician order, dated 5/26/11 for OT (occupational therapy) eval (Evaluation and Treatment) as indicated for A and E (assessment and evaluation) and possible right hand positioning devices." At this time, the MDS coordinator indicated on the resident's right hand, her index finger and thumb were without limitation. She also indicated the remaining 3 fingers on the resident's right hand were resting in a manner which appeared pulled to the right (or lateral side) and the MDS coordinator demonstrated the resident was not able to separate her fingers to the full extent. On 5/27/11 at 10:50 A.M., the DON (Director of Nursing) was interviewed. She indicated the facility wanted the			

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	resident to be as independent as possibly with her eating. 3.1-35(a)			
F0310 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. Based on observation, interview and record review, the facility failed to assess, plan and implement care to assist a resident to remain as independent as possible in skills for eating for 1 of 3 sampled residents reviewed for meal consumption in the restorative dining room in a sample of 12. Resident #1 Findings include:	F0310	F 310 Resident #1 has been evaluated by therapy and a plan of care has been initiated to assist her to remain as independent as possible in skills for eating. **Completion Date 05/26/2011** All residents have the potential to be affected by the alleged deficient practice therefore through systemic changes stated below the campus will ensure the residents remain as independent as possible.	06/26/2011

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	The clinical record of Resident #1 was reviewed on 5/24/11 at 1:00 P.M. Diagnoses included, but were not limited to, the following: dementia with psychotic features, osteoarthritis, transient ischemic attacks, and depression. The most recent MDS (Minimum Data Set) assessment, dated 5/3/11, indicated the following for the resident's range of motion: no impairment for upper extremity (shoulder, elbow, wrist and hand). A total summary score of 4 for cognition, indicated the resident was severely impaired. A speech therapy discharge summary, dated 1/12/11, indicated the following "Reason for Referral" "Pt. (patient) referred to therapy after recent decline in status. Pt is not doing better and desires to eat..." A plan of care, dated 2/9/11, addressed the following problem: "ADL (activities of daily living) self-care deficit...needs assistance or is dependent in...Eating...Interventions included, but were not limited to, the following: Assess/record self-care status changes; report significant changes in ADL status...provide restorative nursing, eating...provide only the amount of assistance/supervision that is needed with ADL'S..."		**Completion Date 06/26/2011** An in service was completed with nursing staff related to assisting residents to remain as independent as possible. All staff has been in serviced on the therapy communication tool. Systemic change is initiation of a therapy communication for all staff to use to notify therapy of a change noted in a resident. **Completion Date 06/26/2011** DHS/designee will perform audits of 3 random residents to assure residents have been assessed and the plan of care is implemented to assist residents to remain as independent as possible 5x week x one month then 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments **Completion Date 06/26/2011**	

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	A plan of care, dated 2/9/11, addressed the following problem: "Alteration in comfort (arthritis). Interventions included, but were not limited to, the following: "Assist resident with ADLS as needed, encourage resident to consume 75-100% of ordered diet...encourage resident to exercise...." A Restorative Care Progress Note, dated 3/25/11, indicated the following: "Weekly Note: Staff cont (continue) to see res (resident) for AROM (active range of motion) BUE (bilateral upper extremities)...et (and) eating. She is provided with V.C. (verbal cues) et (and) demo (demonstration) she will return. 10 reps (repetitions) of flexion/extension exercises. She has limited range. She is also eating all meals in rest (restorative) dining room. She is served mechanical soft diet with thin liquids. Her meal is set up et (and) v.c. given. She will attempt self feeding however it varies. Staff assist as needed et she tolerates diet..." A plan of care, dated 4/11/11, addressed the following problem: "Restorative Dining." The documented goal was "Resident will feed self at least 75% of meal x 90 days." Interventions included, but were not limited to, the following: "Provide tray set up, gives cues and			

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	encourage to eat, assist as needed with meal consumption." On 5/24/11 at 8:30 A.M., Resident#1 was observed in the Restorative Dining room. She was sitting at the table with the following food in front of her: fried egg (uncut), a dish of dry cereal, a Danish roll (uncut), one slice of toast and a standard, regular, uncovered glass of orange juice. The resident was observed with a fork in her right hand, with the handle of the fork between the resident's right thumb and right index finger. The remaining three fingers of the resident's right hand were observed to be straight but in a slanted position, pulled to the right, starting at the base of the knuckle. The resident was heard to say, as she was stabbing at her fried egg with her fork, "I can't get ahold of it. I can't get it." The resident had stabbed the edge of the egg, with it dangling from one fork tine. LPN #1 came over to the table and stated, "I'll cut it in half." After the fried egg was cut in half, the resident was able to spear the egg and took it to her mouth. The resident was observed to be eating with standard utensils and a standard plate without any adaptive device. At 8:45 A.M., LPN #1 stated to Resident #1, "Are you going to eat Raisin Bran?" LPN #1 took a small glass of milk and			

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poured it over the dry cereal. Resident #1 then reached for the standard spoon and grabbing the end of it again with her right thumb and index finger tried to takes bites of the cereal flakes. Resident #1 moved the spoon from the cereal bowl to her mouth with no cereal in the bowl of the spoon for 3 of 5 attempts at eating the cereal.

On 5/24/11 at 12:05 P.M., Resident #1 was observed in the dining room. She was struggling to pick up her fork with her right hand. The fingers of her right hand were positioned in a fanning manner to the right of her palm. CNA #7 stated, "I'm going to help you," and came over to the resident and began feeding her. CNA #7 did not encourage the resident to eat independently but fed the resident.

On 5/26/11 at 10 A.M., the DON (Director of Nursing) was interviewed. She indicated she did not find documentation where the therapy department had assessed the resident regarding her eating/self feeding skills.

On 5/26/11 at 1:30 P.M., the DON was interviewed. She indicated they had called the physician office to get an order for therapy to evaluate the resident.

On 5/27/11 at 6:50 A.M., a copy of the

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	"rehabilitation screen" was received from the DON (Director of Nursing). This change in status form was dated 5/26/11. Findings include: "Screen for possible AE (assessment and evaluation) needs at meals, 5/26/11 lunch - wouldn't attempt to hold utensil, only roll. Dinner-held utensil without any difficulty when she has it in her hand - grabs for food with her hands...may benefit from plate guard...." On 5/27/11 at 10:30 A.M., the MDS coordinator was interviewed. She indicated she didn't know when the change in the resident's right hand occurred but she will complete a change in condition MDS regarding the resident's limitations in her right fingers. At this time, the ADON (Assistant Director of Nursing) indicated they had received a physician's order, dated 5/26/11, for OT (Occupational Therapy) eval (evaluation) as indicated for A and E (Assessment and Evaluation) and possible right hand positioning devices." At this time, the MDS coordinator indicated on the resident's right hand, her index finger and thumb were without limitation. She also indicated the remaining three fingers on the resident's right hand were resting in a manner which appeared pulled to the right (or lateral side) and the MDS coordinator demonstrated the resident was not able to separate her fingers to the full extent.			

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	On 5/27/11 at 10:50 A.M., the DON (Director of Nursing) was interviewed. She indicated the facility wanted the resident to be as independent as possibly with her eating. 3.1-38(a)(2)(D)			
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview the facility failed to provide incontinent care for 1 of 5 incontinent residents in a sample of 12. Resident # 33 Findings include: The clinical record of Resident #33 was reviewed on 5/23/11 at 2:10 P.M. The 4/05/11 Minimum Data set Assessment (MDS) indicated the resident was frequently incontinent. A 4/05/11 care plan for skin protection indicated the resident was to be turned and repositioned every two hours and incontinence care provided after each incontinent episode. During observation on 5/24/11 at 2:12	F0312	F 312 Resident #33 suffered no ill effects in alleged deficient practice. **Completion Date 06/26/2011** All incontinent residents have the potential to be affected by the alleged deficient practice and through changes in provision of care and inservicing will prevent the recurrence of the deficient practice. **Completion Date 06/26/2011** An in service was completed for nursing staff concerning residents receiving incontinent care to have proper procedure followed.Systemic change includes all caregivers to complete return demonstration of all incontinent care skills. **Completion Date 06/26/2011** DHS/designee will perform audits of 3 random residents who are incontinent for	06/26/2011

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	P.M., CNA #8 and CNA #9 were preparing to care for Resident #33. During interview at this time, CNA #8 indicated, "We are going to reposition her. It's over two hours now." The resident was lying on her left side in the bed with a pillow bolstered against her back to maintain her position. CNA #8 asked the resident if she needed to go to the bathroom, to which the resident replied she did not. CNA #8 replied, "Well then, we'll get you repositioned." The CNAs rolled the resident onto her back and then onto her right side with pillow bolstered against her back to maintain her position on that side. CNA #8 was interviewed and indicated the resident did wear incontinent briefs. After being made aware the resident had not been checked for incontinence, she proceeded to check the resident. CNA #8 pulled down the resident's slacks and quickly checked the moisture indicator strip. The visibility of the indicator was occluded by the resident's slacks, which were not pulled down below the brief crotch. She indicated, "It's yellow. She's dry." At that time, re-visualization with improved visibility was requested, and the strip was thoroughly blue from front to back. CNA #8 indicated the resident was actually wet, because the indicator was blue. The blue color indicator was consistant with a moderate amount of incontinent urine		compliance 5x week x one month then 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comment **Completion Date 06/26/2011**	

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	observed in the soiled brief. CNA #8 and # 9 then provided appropriate skin cleansing and care. 3.1-38(a)(3)(A)			
F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure residents at risk for developing pressure sores and/or with pressure sores were assessed in a timely manner and had preventative measures in place for 2 of 4 residents reviewed with pressure areas and/or at risk for developing pressure areas in a sample of 12. Resident #30, Resident #33 Findings include: 1. The clinical record of Resident #30 was reviewed on 5/23/11 at 11:30 A.M. Diagnoses included, but were not limited	F0314	F 314Resident #30 has a pressure reducint cushion. Resident #33 had a head to toe assessment completed a the time of discovering area. The resident was free of any other areas.Completion Date: 05/24/2011 (Resident #30) 04/18/2011 (Resident #33)All residents have the potential to be affected by the alleged deficient practice and through altercations in processes and in-servicing the campus will ensure measures to prevent the development of pressure areas.Completion Date: 06/26/2011Nursing staff have been in-serviced on pressure ulcer prevention. Systemic change is upon admission a pressure reducing cushion will be	06/26/2011

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	to, the following: diabetes, left total knee replacement and severe osteoarthritis. The admission MDS (Minimum Data Set Assessment), dated 5/20/11, indicated the following for the resident: independent cognition; at risk for developing pressure sores; one unstageable pressure ulcer (known but unstageable due to coverage of wound bed by slough and/or eschar); skin ulcer and treatments (pressure reducing device for chair and bed). The resident was admitted to the facility on 5/13/11. An admission assessment, dated 5/13/11, indicated the following: transfers and ambulation with 1 - 2 assistance; weight bearing as tolerated; cognition, confused; in the last 5 days occasionally received pain medication for left knee pain; no known pressure area present; pressure relieving device to chair and bed; no evidence of arterial insufficiency; skin plan of care included but not limited to provide pressure relieving device in chair and bed; assist with positioning in bed and chair; elevate heels off surface; assist with positioning in bed and chair. Nurses notes, dated 5/13/11 at 3:30 P.M., indicated the following: "...left lower extremity (LLE) immobilizer on while up...."		initiated and CNAs will be in-serviced on the use of Continuous Pressure Ulcer Prevention Tool.Completion Date: 06/26/2011DHS/Designee will perform random audits of CNA care to assure following standards of care to prevent pressure ulcers on 3 random residents 5x weekly x 1 month, then 3x weekly x 1 month, then weekly with results forwarded to the QA Committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completion Date: 06/26/2011	

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	An "Assessment Review and Considerations" form dated 5/16/11 indicated the following: "This resident has the following risk factors that may contribute to skin breakdown: mobility impairment...medical diagnosis affecting skin oxygenation...diabetes, LTKR (left total knee replacement)...weekly skin assess (assessments)...Pain Risk...medical diagnosis...recent surgery (LTKR) A Skilled Nursing Assessment and Data Collection form, dated 5/17/11, indicated the following: "skin impairment: surgical wound." On 5/19/11 a "Pressure/Stasis/...Diabetic Ulcer Assessment" form indicated the following: Initial identification date 5/19/11; area not present on admission; right heel pressure area; unstageable; length 2.0 cm (centimeters) width 2.0 cm and depth under 0.1 cm; treatment right heel off load bil (bilateral) heels while in bed, right heel left boot on while in bed. On 5/23/11, during initial tour of the building at 10:00 A.M., the resident was observed in his room in his wheelchair without a pressure reducing cushion. On 5/24/11 the resident's care was observed from 7:40 A.M. until 12:20 P.M. The resident was observed with an			

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	immobilizer to his left leg. The immobilizer extended from above the left knee to just above the left ankle area. The resident was toileted and placed in his wheelchair at 8:15 A.M., without a pressure reducing cushion in the wheelchair base. At 8:20 A.M., the resident was wheeled to the dining room. The resident remained in his wheelchair and was pushed to the therapy department at 9:15 A.M. The resident remained in his wheelchair in the therapy department until he was observed in his room, still in his wheelchair at 11:15 A.M. On 5/24/11 at 11:20 A.M., PT (Physical Therapist) #1 was interviewed. She indicated she had cared for Resident #30 today. She indicated the resident had not walked today for therapy but only worked on his upper body while in the therapy department and had remained in his wheelchair. On 5/24/11 at 11:45 A.M., CNA #5 and CNA #6 were interviewed. They indicated they had not provided any care for the resident since toileting him prior to breakfast. On 5/24/11 at 12:45 P.M., the resident was toileted and observed with first position change since 8:15 A.M.			

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	On 5/25/11 at 12:50 P.M., the resident's right heel was observed. The right heel was observed to have a grayish cast to it but a dark area was not observed. On 5/27/11 at 7 A.M. a current copy of the facility's policy and procedure for "pressure prevention guidelines" was received from the DON. This policy and procedure was undated. The documented purpose of this policy and procedure was "To maintain good skin integrity and avoid development of pressure ulcers. Procedure: Care plan interventions shall be implemented based on risk factors identified in the nursing assessment. Interventions may include but not be limited to:...Protect...and float heels as needed...obtain an advanced pressure reduction cushion for wheelchair; elevate heels off the bed..." On 5/27/11 at 8:07 A.M., the DON (Director of Nursing) provided a current copy of the facility policy and procedure for "Weekly Skin Assessment Guideline." This policy and procedure was dated 4/08. This policy included, but was not limited to, the following: "In addition to the weekly assessment by the licensed nurse the nursing assistant shall observe the skin for areas of impairment with bathing and daily dressing and pericare and notify the nurse if an area is identified." The DON			

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	was also interviewed at this time. She indicated the resident had been admitted to the facility on 5/13/11 and wasn't yet due for a weekly skin assessment. She indicated the staff should perform ongoing skin assessments. 2. The clinical record of Resident #33 was reviewed on 5/23/11 at 2:10 P.M. Diagnoses included, but were not limited to, the following: degenerative joint disease, epilepsy, osteoporosis and hyponatremia. The most recent MDS, dated 4/5/11, indicated the following for the resident: severely impaired cognition; transferring required extensive assistance; resident at risk for pressure sores; no unhealed pressure sores; pressure reducing devices for chair, bed and turning and repositioning program. A plan of care, dated 3/28/11, addressed the following problem: "skin condition." Interventions included, but were not limited to, the following: Assess/record changes in skin status." The intervention "prevent pressure to area" was not checked as an intervention. A Change in Condition Form, dated 3/28/11, indicated the following: "Res (resident) has two blood blisters to back of right lower leg...."			

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	A physical therapy progress report, with the period from 3/29/11 to 4/4/11, indicated the following for bed mobility: "Pt (patient) rolls and transfers sit/supine with max assist of 1 -2. A "Change in condition form" dated 4/18/11 indicated the following: "Res has 2 cm x 2 cm pressure area blackened to R heel..." A "Pressure/Stasis/...Ulcer Assessment" had an initial date of 4/18/11, for the location of the right heel. This form indicated this area was not present on admission, stage of "E (non-stageable due to necrotic tissue present), length 2.0 , width 2.0 and depth under 0.1 (no measure scale was defined)." The most recent measurement for this area was 5/18/11 with length 1.0 cm, width 1.0 cm and depth under 0.1 cm; wound margins intact and surrounding tissue "pink." Another plan of care,dated 4/19/11, addressed the problem of "alteration in skin integrity AEB (as evidenced by) pressure ulcer, rt (right) heel stage E (eschar)." Interventions included. but were not limited to, the following: "Examine skin daily for signs of redness, discoloration. Assess areas prone to breakdown especially over bony prominence...turn and reposition every 2			

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	hours...." The Treatment Record for April 2011 was reviewed with the clinical record. This form indicated the resident had a weekly skin assessment on 4/12/11 and then on 4/19/11. For the 4/19/11 assessment, a "2" was documented, which from the form indicated "existing" area. Also on the Treatment Record, a "skin check completed" was documented on 4/18/11. On 5/23/11 at 1:50 P.M., the resident's right heel was observed. The area was approximately the size of a 5 cent coin and was open with well defined edges. On 5/27/11 at 10:40 A.M., the DON was interviewed. She indicated for both Resident #30 and #33, the pressure areas were initially found at an unstageable condition. 3.1-40(a)(1) 3.1-40(a)(2)			

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F0332 SS=E	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5%. Nine residents were observed receiving medications. Five errors in medication adminisistration were observed during 49 opportunities for error in medication administration. This resulted in a medication error rate of 10.2%. This deficient practice affected 2 of 2 residents observed receiving medications in a sample of 12 and 3 of 4 in a supplemental sample of 7. Resident #45, Resident #39, Resident #17, Resident #25, Resident #9 Findings include: 1. On 5/24/11 at 8:25 A.M., LPN #2 began to prepare oral medications for Resident #39. LPN#2 indicated this resident was prone to having a gagging reflex when taking oral medications. LPN #2 indicated she needed to crush the resident's oral medications for administration . LPN #2 at this time crushed the following medications: aspirin 81 mg, Atenolol 25 mg, Namenda 5 mg, Pepcid 40 mg and Wellbutrin SR (sustained release) 150 mg. She then administered these crushed oral medications to Resident #39.	F0332	**F 332** Resident #45, #25, #39, #17 and #9 suffered no ill effects **Completion Date 05/24/2011** All residents have the potential to be affected by the alleged deficient practice and through altercations in processes and in servicing the campus will ensure measures to prevent medication errors **Completion Date 06/26/2011** Nursing staff have been in serviced on medication orders regarding passing medications Systemic change is all nurses and QMAs will complete a medication pass competency now and annually thereafter. **Completion Date 06/26/2011** Nurse managers will observe medication pass on 5 random residents 5x week x one month 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments **Completion Date 06/26/2011**	06/26/2011

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The 2010 Nursing Spectrum Drug Handbook page 163, indicated the drug Wellbutrin SR (sustained release) "Administration: Be aware that sustained-release tablets should be swallowed whole and not crushed or chewed...."

On 5/25/11 at 9:55 A.M., the Director of Nursing (DON) provided facility documentation entitled, "Medications Not To Be Crushed." This documentation included the medication Wellbutrin SR. The DON indicated the physician was at the facility last evening and had now signed a form for the resident to receive the medication Wellbutrin SR crushed.

2. On 5/24/11 at 11:05 A.M., LPN #2 indicated Resident # 45 had a accucheck (blood sugar test) ordered for 11:00 A.M. LPN#2, then performed the accucheck and documented a blood sugar number of 343. LPN #2 indicated at this time she would not administer the sliding scale insulin ordered for the blood sugar of 343 (elevated blood sugar) until after the resident had completed her lunch.

Review of Resident #45's current physician's orders at this time indicated orders included, but were not limited to: Insulin Novolog Flexpen S/S (sliding

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	155674	A. BUILDING 00 B. WING	05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CHARLES HEALTH CAMPUS	3150 ST CHARLES ST JASPER, IN47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	scale dosage) at 8:00 A.M., 11:00 A.M., 4:00 P.M., and 9:00 P.M. BS (blood sugar) ranges for sliding scale insulin were: 71-150= 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-400 = 4 units, 351-400 = 5 units, if > 400 call MD. A physician telephone order dated 5/17/11, indicated to discontinue current sliding scale insulin dosage and start sliding scale Novolog to 200-250 = 4 units, 251-300 = 6 units, 301-350= 8 units, and 351- 400 = 10 units. On 5/24/11 at 1:30 P.M., LPN #2 indicated she was going to administer the sliding scale insulin for the 11:00 A.M., 343 blood sugar. At his time LPN #2 administered the 8 units of Novolog insulin. On 5/26/11 at 8:50 A.M., during interview with the DON, she indicated sliding scale insulin should be given as ordered at time of accucheck. 3. On 5/24/11 at 3:45 P.M., LPN #1 indicated she was going to pass afternoon medications (4:00 P.M. and 5:00 P.M.). On 5/24/11 at 3:55 P.M., Resident #17 received her oral Tramadol (pain) 50 mg as ordered. On 5/24/11 at 4:10 P.M., Resident #17's clinical record regarding physician medication orders was reviewed. An order for the oral			

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	medication Ferrex 50 mg (plus capsule) daily for anemia at 5:00 P.M., was noted to be ordered. During interview at this time, in regard to the Ferrex not being administered with all the resident's 4:00 P.M. and 5:00 P.M., medications as planned, LPN #1 indicated she had missed this medication. LPN #1 then told Resident # 17 that she hadn't given her the Ferrex medication and administered the medication at this time. 4. On 5/25/11 at 9:45 A.M., LPN #2 was observed administering medications to Resident # 25. The LPN was informed the resident had expressed an omission concern during a 9:00 A.M. interview. The nurse indicated she had not realized she omitted administration of Prilosec OTC 20mg at 7:00 A.M. The LPN interviewed the resident, who indicated she took one pill before breakfast (which she usually ate around 8:30 A.M.) and she had finished breakfast "long ago." She indicated she understood how "busy the girls are, sometimes have to give them (medications) all together." The nurse administered the Prilosec OTC 20 mg with the rest of the morning medications at 9:45 A.M. The clinical record of Resident #25 was reviewed on 5/25/11 at 10:15 A.M. There was a 12/29/10 physician order for			

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	Prilosec OTC 20 mg at 7:00 A.M., daily. The facility reference book PDR 2011 Edition Nurse's Drug Handbook page 871 indicated Prilosec should be taken before eating. 5. On 5/24/11 at 3:15 P.M., LPN #1 was observed administering medication to Resident #9. Along with the scheduled 3:00 P.M. medications she also gave a dose of Famotidine 20mg by mouth. The clinical record was reviewed on 5/24/11 at 4:00 P.M. There was a physician order 12/09/10 for famotidine 20mg (for control of gastric acidity) orally, upon rising and at 5:00 P.M. 3.1-25(b)(9) 3.1-48(c)(1)			
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to ensure sliding scale insulin was administered in a timely manner for 2 of 3 residents reviewed for sliding scale insulin administrations and an oral laxative medication order frequency change was not timely for greater than a 2 month	F0333	F 333Resident #45, #4, and #16 suffered no ill effects and the MAR was changed to reflect the current order.Completion Date: 05/24/2011All residents have the potential to be affected by the aleged deficient practice and through altercations in processes and in-servicing the campus will ensure measures to prevent medication errors.Completion	06/26/2011

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	period for 1 of 5 residents reviewed for constipation medication. The deficient practice affected 3 residents in a sample of 12 and a supplemental sample of 7. Resident #45, Resident #4, Resident #16 Findings include: 1. On 5/24/11 at 11:05 A.M., LPN #2 indicated Resident # 45 had a accucheck (blood sugar test) ordered for 11:00 A.M. LPN #2 performed the accucheck and documented a blood sugar number of 343. LPN #2 indicated she would not administer the sliding scale insulin ordered for the blood sugar of 343 (elevated) until after the resident had completed her lunch. Review of Resident #45's current physician's orders at this time indicated orders included, but were not limited to: Insulin Novolog Flexpen S/S (sliding scale dosage) at 8:00 A.M., 11:00 A.M., 4:00 P.M., and 9:00 P.M. BS (blood sugar) ranges for sliding scale insulin were: 71-150= 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-400 = 4 units, 351-400 = 5 units, if > 400 call MD. A physician telephone order dated 5/17/11, indicated to discontinue current sliding scale insulin dosage and start sliding scale Novolog to 200-250 = 4		Date: 06/26/2011Nursing staff have been in-serviced on medication orders regarding passing medications and transcription of medication orders/lab orders. Systemic change is physician orders transcribed to the medication administration sheet or treatment administration sheet will be reviewed by the DHS/Designee. All nurses and QMAs will complete a medication pass competency now and annually thereafter.Completion Date: 06826/2011Nurse Managers will perform random audits of medication administration sheets and treatment administration sheets to review for medication errors or missed labs on 5 random residents 5x weekly x 1 month, then 3x weekly x 1 month, then weekly with results forwarded to the QA Committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completio n Date: 06/26/2011	

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	units, 251-300 = 6 units, 301-350= 8 units, and 351- 400 = 10 units. On 5/24/11 at 1:30 P.M., LPN #2 indicated she was going to administer the sliding scale insulin for the 11:00 A.M., 343 blood sugar. At this time LPN #2 administered the 8 units of Novolog insulin. On 5/26/11 at 8:50 A.M., during interview with the Director of Nursing (DON), she indicated sliding scale insulin should be given as ordered at time of accucheck. 2. On 5/24/11 at 1:50 P.M., LPN #1 was interviewed regarding an insulin injection she had just given. LPN#1 at this time indicated she had just given Resident #4 at 1:45 P.M., 3 units of Humalog insulin (sliding scale insulin) for a 275 accucheck blood sugar completed at 11:45 A.M. She indicated she had been unable to do the accucheck (blood sugar test) ordered daily at 11:00 A.M. until at 11:45 A.M. Resident #4's current physician orders were reviewed at this time and included an order initiated 4/1/09, for accucheck before meals and at bedtime 6:00 A.M., 11:00 A.M., 4:00 P.M., and 8:00 P.M.. A physician telephone order dated 4/15/11, indicated to discontinue Novolog sliding scale insulin and replace with Humalog sliding scale insulin. The Humalog			

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	sliding scale range was: 60-150 = zero units, 151- 200 = 1 unit, 201 - 250 = 2 units, 251 - 300 = 3 units, 301 - 350 = 4 units, 351- 400 = 5 units, and > 400 = 6 units and call physician. On 5/25/11 at 12:20 P.M., during interview with the Director of Nursing (DON), she indicated medications should be administered as ordered in regard to sliding scale insulin to be given as ordered at time of accucheck. 3. On 5/24/11 at 4:00 P.M., during observation of the medication pass Resident #16 received the oral medication Fiber lax (Fiber-Con) (625 mg). After the medication had been administered LPN #1 documented the medication had been given on the Medication Administration Record (MAR) of today's date, 5/24/11. The May 2011 MAR had a line marked through every other day's date which indicated the medication was to be given every other day. The May 2011 MAR indicated, " Fiber-Lax Captabs Fibercon 625 mg caplet give 1 tab orally 2 x/day every other day for fiber (order date 8/26/10)." On 5/24/11 at 4:11 P.M. Resident #16's clinical record was reviewed related to physician orders. A telephone order, dated 3/2/11, included but was not limited			

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	to the order: "... Fiber-Con 625 mg i tab po (orally) at 12N & supper...." On 5/24/11 at 4: 11 P.M., LPN #1 was made aware of physician order dated 3/2/11, which instructed Fiber-Lax was to be given twice a day. On 5/24/11 at 4:20 P.M., LPN #1 indicated the medication order had not been changed on the MAR after the telephone order had been received on 3/2/11. The 2011 March and April MAR indicated the resident received the Fiber-lax medication twice a day every other day. 3.1-25(b)(9) 3.1-48(c)(2)			
F0387 SS=E	The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. Based on record review and interview, the facility failed to ensure 4 of 4 residents,	F0387	F 387 Resident # 3, 16, 2, and 37 suffered no ill	06/26/2011

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	reviewed for timely visits, from a sample of 12, were seen by physicians every 30 days for the first 90 days of residence and/or every 60 days thereafter. Resident # 3, Resident #16, Resident #2, and Resident #37 Findings include: 1. The clinical record of Resident #3 was reviewed on 5/23/11 at 2:00 P.M. The resident had been admitted on 6/08/10. The physician did not visit until 7/29/10. The attending physician visited 8/30/10 and 12/09/10, missing the 9/30/10 visit. There were no visits between 2/10/11 and 5/24/11 (missing the visit which was due 4/10/11). 2. The clinical record of Resident # 16 was reviewed on 5/23/11 at 2:10 P.M. The resident had been admitted on 9/21/05. Documentation was lacking of an attending physician visit between 1/12/11 and 5/02/11 (visit due 3/12/11). 3. The clinical record of Resident #2 was reviewed on 5/23/11 at 2:20 P.M. The resident had been admitted on 8/20/10. Documentation was lacking of an attending physician visit from 12/08/10 to 5/24/11 (visit due 2/08/10). 4. The clinical record of Resident # 37		effects from the deficient practice. All the above residents where seen prior to the state department of health exiting the campus. **Completion Date 05/24/2011** All residents have the potential to be affected by the alleged deficient practice and through alterations in processes will ensure residents are visited by a physician once every 30 days for the first 90 days and at least once every 60 days thereafter. **Completion 06/26/2011** Systemic change medical records nurse to maintain a tickler system monitoring last physician visit to assure residents seen every 30 days for first 90 days and at least once every 60 days thereafter. **Completion Date 06/26/2011** DHS or designee will audit tickler system once a week to assure compliance with visits with results being forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. **Completion Date 06/26/2011**	

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	was reviewed on 5/23/11 at 2:25 A.M. The resident had been admitted on 2/02/10. Documentation was lacking of an attending physician visit between 1/12/11 and 3/30/11 (visit due 3/12/11). 5. On 5/27/11 at 10:30 A.M., the Director of Nursing was interviewed regarding timely physician visits. She indicated the facility had a system in place whereby physicians were notified 10 days before the delinquent date for visits due. She was unsure how the system had failed to prevent the problem. 3.1-22(d)(1) 3.1-22(d)(2)			
R0000	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R0000	Plan of Correction Text: The submission of this plan of correction does not indicate an admission by St Charles Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of St Charles Health Campus. This facility recognizes it's obligation to provide legally and medically necesary care and services to its residents in an economic and	

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			efficient manner.The facility herby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. (for Title 18/19 programs)To this end, this plan of correction shall seve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	
R0240	(d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure assisitive devices were in use to prevent falls for 1 of 5 residents reviewed for falls in a sample of 5. Resident #21 Findings include: Resident #21's clinical record was reviewed on 5/26/11 at 1:00 P.M. His current service plan with a date of 4/25/11, indicated resident was alert and oriented and required physical assistance for transfers. Diagnoses included, but were not limited to: essential tremor and right hemiparsis (one side paralysis). A nursing note dated 12/28/10 at 8:30 P.M., indicated, " Called to Rm (room number) @ this x (time) by CNA. Res. (resident) was getting into bed c (with)	R0240	R 240 Resident 21 did not suffer any ill effects from the alleged deficient practice. **Completion Date 06/26/2011** All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will ensure assistive devices are used to prevent falls. **Completion Date 06/26/2011** Nursing staff have been in serviced concerning Fall/Safety Management and use of gait belts for transfers. Systemic change is that caregivers will sign A Guidelines for Gait Belt Use Form. **Completion Date 06/26/2011** DHS /designee will monitor 3 random resident at risk for falls to assure assistive devices are used to prevent falls	06/26/2011

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	CNA A(assistance) et lost balance et fell to the side to the floor. Full ROM (range of motion) performed s (without) pain or difficulty. 0(zero) injuries noted..." "... CNA admits not using gait belt on res. Educated res. to transfer properly. Educated staff on gait belt use et proper transfers..." A fall circumstance, assessment and intervention form dated 5/21/11 at 8:40 P.M., was reviewed. This documentation indicated the resident was being transferred from a chair to the bed with the assistance of one staff without a gait belt. The prevention intervention initiated was to: "Caregiver counseled on need to use gait belt c (with) transfers." On 5/27/11 at 10:50 A.M., the nurse unit manager was interviewed regarding the falls of 12/28/11 and 5/21/11. She indicated that different staff (CNAs) were assisting the resident at the time of the two different falls.		5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments **Completion Date**	